

CONFIDENTIAL QUESTIONNAIRE OF INTRODUCTION

Sex: M F Last Name: _____ First Name: _____

Address: N° : _____ Street: _____ Apt.: _____

City: _____ Postal Code: _____

Tel. Res.: _____ Work: _____ Cell.: _____

Birthdate: Year: _____ Month: _____ Day: _____ E-mail: _____

Medicare No.: _____ Expiry Date: _____ Social Insurance No. (optional): _____

If you are less than 18 years old, indicate name of parent or guardian

Mr. Mrs.

For an emergency, contact: _____

Motive for visit: _____ Referred by: _____

MEDICAL HISTORY

Weight _____ Height _____

1. Are you presently under a doctor's care? Yes No
If so, reason: _____

Last Name: _____ First Name: _____
Tel.: _____ (Ext.): _____

2. Are you presently taking any drug or medication, or have you taken any in the last six months? Yes No
If so, which: _____

3. Are you presently taking natural or homeopathic products? Yes No
Specify: _____

- Birth control pills
- Hormones: Specify: _____

4. Did you recently experience a significant weight loss or gain? Yes No

5. Are you pregnant? Yes No
Are you breastfeeding? Yes No

Are you suffering or have you ever suffered from:

6. Heart disease (stroke, angina, valvular problems, murmur) Yes No

7. Rheumatic fever Yes No

8. Blood problems

8.1 Hemophilia Yes No

8.2 Prolonged bleeding Yes No

8.3 Clear blood Yes No

8.4 Anemia Yes No

8.5 Others: Specify: _____ Yes No

9. High Low Blood pressure Yes No

10. Frequent colds or sinusitis Yes No

11. Tuberculosis or lung problems Yes No

12. Digestive problems: Specify: _____ Yes No

13. Stomach ulcer Yes No

14. Liver disease (hepatitis A, B, C, cirrhosis, etc.) Yes No

15. Kidney problems Yes No

16. Do you urinate often? Yes No

17. Venereal disease (V.D.) Yes No

18. Diabetes Yes No

19. Thyroid problems Yes No

20. Skin disease Yes No

21. Eye problems Yes No

22. Arthritis Yes No

23. Osteoporosis Yes No

Do you take bisphosphonates? Yes No

24. Epilepsy Yes No

25. Nervous disorders Yes No

26. Mental illness Yes No

Specify: _____

27. Frequent headaches Yes No

28. Dizzy spells or fainting spells Yes No

29. Earaches Yes No

30. Hay fever Yes No

31. Asthma Yes No

32. Do you smoke? Yes No

33. Have you ever had radiotherapy or/and chemotherapy treatments (tumor)? Yes No

34. Do you have AIDS symptoms? Yes No

35. Are you an AIDS virus carrier? Yes No

36. Do you have artificial joints (knee, hip, etc.)? Yes No

37. Do you snore or have you ever been told that you snore? Yes No

38. Do you have any of the following allergies?

38.1 Latex 38.6 Penicillin

38.2 Food 38.7 Codeine

38.3 Iodine 38.8 Other antibiotics

38.4 Aspirin 38.9 Local anaesthesia

38.5 Sulfonamides 38.10 Others

Specify: _____

39. Do you use drugs? Yes No

40. Do you drink alcohol?
No/A little In moderation A lot

41. Were you ever hospitalized or have you undergone surgery other than dental? Yes No

If so, why and when: _____

_____ date _____

_____ date _____

_____ date _____

42. Do you fear dental treatments?
A little A lot Not at all

43. Is there anything concerning your health you wish to discuss privately with your dentist? Yes No

Remarks: _____
